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To the Honorable Senate and House of Representatives:

For the past 50 years, the US health care system has been focused primarily on promoting and supporting the technological advancement of medicine. That focus has cured disease, enhanced therapies, and saved lives. But as that focus, and the success it has achieved, has dominated what and how we pay for health care, we have failed to appreciate the changing nature of illness, and the systemic gaps in care delivery that have been created by this approach.

One need look no further than the opioid epidemic to understand what we have missed. The overprescribing of addictive and potentially deadly pain medication, brought on by a system in which it is more financially beneficial to write a prescription than it is to provide supportive and sustained therapy, created an addiction epidemic of gargantuan proportions.

While many people would argue that the fundamental problems with our health care system are rooted in some provider organizations being paid too much, and others being paid too little, we would argue the problem is more fundamental than that. Our health care system rewards those providers that invest in technology and transactional specialty services, at the expense of those that choose to invest in primary care, geriatrics, addiction services and behavioral health care.

This is problematic for three reasons. First, the nature of illness is changing. Chronic illnesses are far more prevalent than they used to be, in part because of the success of modern medicine in solving many kinds of acute illness over the past five decades. Second, we are an aging population. Many of us who live to the age of 60 will make it into our 80s and 90s, where brain diseases are far more common than they used to be, again in part because of our success in treating heart disease and many forms of cancer. Third, for a variety of clinical and sociological reasons, mental health, addiction and behavioral health issues are far more challenging than they were in the past, and we increasingly recognize how they are intertwined with physical illnesses.

And the primary care shortage that was identified over 30 years ago has gotten worse over the past three decades.

Simply put, the care delivery and financing system we have today is not designed to take care of the people and the patients we have become. We pay for a system that is built on transactions and technological advances, not on collaborative care delivery, therapeutic support, or a combination of both. While technological advances remain a critical component of delivering effective health care, a 21st century health system should presume that collaboration and time are at least as important as technology, and that for many people, physical and mental health are related. It should reward providers and provider organizations that invest in a comprehensive set of physical and behavioral health services, and understand that population based health management requires time and connection.

Solving this problem at the state level is complicated by the overarching role played by public and private national payors in health care in this country. For the most part, national payors, including Medicare, use payment policies that favor technology and transactional medicine at the expense of primary care, mental and behavioral health and addiction services, and ironically, geriatrics. Almost all providers and payors build their financial models and their operations using the Medicare fee schedule as their baseline. This makes any decision to deviate from that model – for example, to offer more mental health services – extremely hard to do.

Federal policy and research funding also drive provider organizations to focus on specialty services and care, instead of on addiction, mental or behavioral health, primary care or geriatrics. This makes it financially difficult for any care delivery organization to double down in the areas where the greatest gaps in the existing care delivery system exist.

The bill I am filing today, "An Act to Improve Health Care by Investing in VALUE," is designed to create positive financial incentives for health care providers and payors to rethink their service delivery and investment decisions. This bill encourages providers and payors to invest in the behavioral health, addiction and recovery, and primary care and geriatric services that are underfunded by today's payment models and incorporate these services more directly into their care delivery strategies.

The legislation targets those challenges by requiring investments in behavioral and primary care and **establishing a statewide spending target.**

- Providers and insurers, including MassHealth, will be required to increase spending on behavioral health and primary care by 30% over three years.
- Calendar year 2019 spending will serve as the baseline, and providers and insurers will be measured on their performance beginning in calendar year 2023.
- The legislation does not suggest a standard pathway for providers and insurers to achieve the target.
- Providers and insurers will be required to report their progress on an annual basis through the Center for Health Information Analysis' (CHIA) and Health Policy Commission's (HPC) existing processes.
- If the target is not achieved, providers and insurers will be referred by CHIA to the HPC and may be subject to a performance improvement plan which may require them to identify strategies and opportunities to increase investments in primary care and behavioral health.

The legislation proposes these increased investments in primary care and behavioral health while requiring overall spending to stay within the parameters of the state's overall health care cost growth benchmark.

This will be a break from the trajectory of the past several decades and may cause some modest disruptions. But even a cursory review of the literature makes clear that this is the right direction for our payment systems and our health care providers to move in if we want to create a payment and care delivery model that properly and cost effectively serves the people of the Commonwealth.

Our bill also builds upon the foundation put forth by prior health care legislation, including Chapter 224, the 2012 cost containment legislation. Recent efforts have yielded moderate success in bending the cost growth curve. However, increasing health care costs disproportionately fall to individuals and employers, as increases in premiums and cost-sharing continue to outpace overall expenditures.

This legislation seeks to address excess costs and spending through a multi-faceted approach that both targets systemic cost drivers and promotes consumer access to high-value, affordable coverage. The bill strengthens the process by which the Health Policy Commission (HPC) evaluates, and holds accountable, entities that exceed the cost growth benchmark.

To address year-over-year increases in pharmacy spend, we seek to:

- hold high-cost drug manufacturers accountable through a similar framework used for payors and providers that exceed the benchmark;
- penalize manufacturers for excessive price increases; and
- establish new oversight authority of pharmacy benefit managers (PBMs).

The bill also includes several consumer protections and measures to reduce consumers' out-of-pocket costs, including prohibitions on surprise billing practices and facility fees, and reforms promoting access to more affordable, innovative health plans for individuals and employers, alike.

Further, a stable and affordable insurance market is key to maintaining our near-universal coverage levels and a well-functioning health care system. To address many of the emerging federal policy changes and dynamics that may impact the Massachusetts merged market, I will be issuing an executive order in parallel, to establish an advisory council to conduct an independent actuarial analysis of the merged market and provide recommendations, including any regulatory or statutory reforms, for improved market functioning no later than April 30, 2020.

Finally, this legislation promotes access to quality, coordinated care and modernizes policies to bring Massachusetts in line with other states in areas where we have lagged behind. These measures include: removing outdated practice restrictions for mid-level clinicians, creating a new mid-level dental therapist, standardizing urgent care services and advancing telemedicine through aligned regulatory and coverage policies.

Managing excess costs in the system and promoting increased access to vital services will support the Commonwealth in recalibrating its health care financing and delivery system towards a model that values time and positive outcomes, and stands prepared to meet the evolving needs of our changing patient populations. Many of the reforms we have proposed will also reduce costs – including to patients and small businesses – while maintaining the quality of care the people of Massachusetts deserve.

We can't afford to wait. I look forward to working with the Legislature to enact comprehensive health care legislation that delivers a more cost-effective, nimble and patient-centric health care system for the 21st century.

Respectfully submitted,

Charles D. Baker
Governor